Partnership Plan
Section 1115 Quarterly Report
Demonstration Year: 18 (10/1/2015 – 9/30/2016)
Federal Fiscal Quarter: 3 (4/01/2016 – 6/30/2016)

I. Introduction

In July 1997, New York State received approval from the Centers for Medicare and Medicaid Services (CMS) for its Partnership Plan Medicaid Section 1115 Demonstration. In implementing the Partnership Plan Demonstration, it was the State's goal to:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered;
- Expand access to family planning services; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

The primary purpose of the Demonstration was to enroll a majority of the State's Medicaid population into managed care, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times. CMS had approved an extension of the 1115 waiver on September 29, 2006 for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2016.

There have been a number of amendments to the Partnership Plan Demonstration since its initial approval in 1997. CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from the recommendations of Governor Cuomo's Medicaid Redesign Team (MRT). CMS recently approved the DSRIP and Behavioral Health amendments to the Partnership Plan Demonstration on April 14, 2014 and July 29, 2015, respectively.

New York State's Federal-State Health Reform Partnership (F-SHRP) Medicaid Section 1115 Demonstration expired on March 31, 2014. Populations in the F-SHRP were transitioned into the 1115 Partnership Plan Waiver. A final draft evaluation report was submitted to CMS on February 11, 2015 and was approved by CMS on May 24, 2016.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as complete and posted the application for a 30 day public comment period. A temporary extension was granted on December 31, 2014 extending the waiver through March 31, 2015. Subsequent temporary extensions were granted through September 15, 2016. Approval of the renewal request will extend the Demonstration until March 31, 2020, thus allowing New

York to reinvest federal savings generated by the MRT reform initiatives, and to reinvest in the state's health care system currently authorized by the Partnership Plan.

New York is well positioned to lead the nation in Medicaid reform. Governor Cuomo´s Medicaid Redesign Team (MRT) has developed a multi-year action plan (A Plan to Transform the Empire State´s Medicaid Program) that when fully implemented will not only improve health outcomes for more than five million New Yorkers but also bend the state´s Medicaid cost curve. Significant federal savings have already been realized through New York´s MRT process and substantial savings will also accrue as part of the 1115 waiver.

II. Enrollment: Third Quarter

Partnership Plan- Enrollment as of June 2016

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 - TANF Child 1 - 20 years in Mandatory Counties as of 10/1/06	**1,159,078**	**12,628**	**54,299**
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	**135,876**	**2,633**	**7,659**
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	**68,659**	**947**	**3,466**
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	**5,765**	**132**	**451**
Population 5 - Safety Net Adults	**903,875**	**17,722**	**31,916**
Population 6 - Family Health Plus Adults with Children	**0**	**0**	**0**
Population 7 - Family Health Plus Adults without Children	**0**	**0**	**0**
Population 8 - Disabled Adults and Children 0 - 64 (SSI 0-64 Current MC)	**42,624**	**1,022**	**246**
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	**227,538**	**8,223**	**1,879**

Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	**2,779**	**403**	**40**
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	**55,528**	**3,656**	**1,252**

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year	**47,366 or an approximate 8% decrease from last Q**

Reasons for voluntary disenrollment: enrollment in another plan; approved enrollee request to qualify as either exempt or excluded; relocation to residence outside county of enrollment; and Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

WMS continues to send select closed cases to New York State of Health. Consequently the disenrollment numbers now draw on a smaller WMS population and involuntary disenrollment also declines.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year	**102,652 or an approximate 1% decrease from last Q**

Reasons for involuntary disenrollment: Loss of Medicaid eligibility.

WMS continues to send select closed cases to New York State of Health. Consequently the disenrollment numbers now draw on a smaller WMS population and involuntary disenrollment also declines.

Partnership Plan Waiver –Affirmative Choices

Mainstream Medicaid Managed Care				
April 2016				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**1,533,021**	**26,324**	**3,517**	**22,807**

Rest of State	**1,089,589**	**20,639**	**2,182**	**18,457**
Statewide	**2,622,610**	**46,963**	**5,699**	**41,264**
May 2016				
New York City	**1,554,767**	**24,219**	**3,909**	**20,310**
Rest of State	**1,101,542**	**21,052**	**3,074**	**17,978**
Statewide	**2,656,309**	**45,271**	**6,983**	**38,288**
June 2016				
New York City	**1,513,332**	**20,204**	**3,065**	**17,139**
Rest of State	**1,074,360**	**16,854**	**1,753**	**15,101**
Statewide	**2,587,692**	**37,058**	**4,818**	**32,240**
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	**60,256**			
Rest of State	**51,536**			
Statewide	**111,792**			

HIV SNP Plans				
April 2016				
Region	**Roster Enrollment**	**New Enrollment**	**Auto-assigned**	**Affirmative Choices**
New York City	**14,102**	**156**	**0**	**156**
Statewide	**14,102**	**156**	**0**	**156**
May 2016				
New York City	**14,224**	**142**	**0**	**142**
Statewide	**14,224**	**142**	**0**	**142**
June 2016				
New York City	**14,030**	**150**	**0**	**150**
Statewide	**14,030**	**150**	**0**	**150**
Third Quarter				
Region	**Total Affirmative Choices**			
New York City	**448**			
Statewide	**448**			

Partnership Plan Waiver –Health and Recovery Plans Enrollment

Health and Recovery Plans- New York City	
June 2016	
Plan Name	**Enrollment**
HealthFirst	**14,770**
HealthPlus	**4,387**
HIP GNY	**3,066**
MetroPlus	**7,942**
NYS Catholic Health Plan	**6,093**
United HealthCare	**2,020**
Total:	**38,278**

Health and Recovery Plans Disenrollment			
Q3 2016			
	Voluntary	**Involuntary**	**Total**
April 2016	**281**	**107**	**388**
May 2016	**500**	**140**	**640**
June 2016	**260**	**138**	**398**
Total:	**1,041**	**385**	**1,426**

III. Outreach/Innovative Activities

Outreach Activities

NYMC Field Observations

As of the end of the third federal fiscal quarter (end of June 2016), there were 2,624,040 New York City Medicaid consumers enrolled in a managed care product. MAXIMUS, the Enrollment Broker for the New York Medicaid CHOICE program (NYMC), conducted in person outreach, education, and enrollment activities in Human Resources Administration (HRA) facilities throughout the five (5) boroughs of New York City.

During the reporting period, MAXIMUS conducted outreach in the following HRA facilities: 7 HIV/AIDS Services Administration (HASA) sites, 10 Community Medicaid Offices (MA Only), and 17 Job Centers (Public Assistance). MAXIMUS reported that 17,307 clients were educated about their enrollment options and that 8,681 (50%) made a voluntary enrollment choice.

HRA's Contract Monitoring Unit (CMU) observed 2,190 one-to-one client informational sessions conducted within its facilities. CMU monitors reported the following:

- 1,471 (69%) clients received general information that included and is not limited to plan transfer, enrollment options, and mandatory enrollment.
- 719 (34%) Fee-for-Service (FFS) clients made a voluntary enrollment choice for themselves and their family members.

Infractions were cited for 81 (11%) of the 719 observed plan selection sessions conducted by NYMC Field Customer Service Representatives (FCSRs). Infractions most often noted were failure to disclose or explain the following:

- Good Cause Transfer;
- Preventive Care;
- How to choose a health plan; and
- Health Assessment Form.

NYMC HelpLine Observations

CMU monitors the NYMC HelpLine for Mainstream Medicaid managed care products only. During the reporting period, NYMC reported that 75,090 calls were received by the Helpline and 69,853 or 93% were answered. Calls answered were handled in the following languages - English: 50,857 (72.8%); Spanish: 11,673 (16.7%); Chinese: 3,676 (5.3%); Russian: 1,269 (1.8%); Haitian: 151 (0.2%); and "other": 2,227 (3.2%).

MAXIMUS records 100% of the calls received by the NYMC HelpLine. CMU listened to 2,668 recorded calls answered for Mainstream clients by Customer Service Representatives (CSRs). The call observations were categorized in the following manner:

- General Information: 1,865 (70%) were FFS clients requesting enrollment information and inquired about accessing plan services.
- Phone Enrollment: 314 (12%) FFS clients made a voluntary phone enrollment choice.
- Plan Transfer: 347 (13%) plan enrollees requested to change their plan.
- Public Calls: 142 (5%): Callers did not have MA eligibility and made inquiries regarding how to apply for coverage and plan enrollment.

Infractions/issues were identified for 821 (31%) of the recorded calls reviewed by CMU. The following summarizes those observations:

- Process: 504 (61%)- CSRs did not correctly document or failed to document the issue presented; did not provide correct information to the caller; or did not repeat the issue presented by the caller to ensure the information conveyed was accurately captured or correct.
- Key Messages: 136 (16%) - CSRs incorrectly explained or omitted how to navigate a managed care plan; use of emergency room; preventative care/explanation of PCP; and, referrals for specialists.
- Customer Service: 181 (22%) - Consumers were put on hold without an explanation.

All infractions are reported monthly to NYMC for corrective actions to be prepared and implemented. Corrective actions include, but are not limited to staff training and an increase in targeted CSR monitoring to ensure compliance.

IV. Operational/Policy Developments/Issues

A. Health Plans

Changes to Certificates of Authority (COA)

- **Affinity Health Plan, Inc. -** Revised COA to change address, updated to add previously approved Medicaid Advantage language, and updated to include the HARP line of business for all counties in their approved Medicaid service areas.

- **Today's Options of New York, Inc. -** Revised COA to include the HARP line of business for all counties in their approved Medicaid service areas.
- **Independent Health Association, Inc.** - Revised COA to include the HARP line of business in their approved Medicaid service areas.
- **New York State Catholic Health Plan, Inc. -** Revised COA to include the HARP line of business in their remaining approved Medicaid service areas outside of New York City.
- **HealthFirst PHSP, Inc.** - Revised COA to include the HARP line of business in their remaining approved Medicaid service areas outside of New York City.
- **Health Insurance Plan of Greater New York, Inc. -** Revised COA to include the HARP line of business in their remaining approved Medicaid service areas outside of New York City.
- **MVP Health Plan, Inc. -** Revised COA to include the HARP line of business in their approved Medicaid service areas.
- **YourCare Health Plan, Inc. -** Revised COA to include the HARP line of business in their approved Medicaid service areas.
- **HealthPlus HP, LLC -** Revised COA to include the HARP line of business in their remaining approved Medicaid service areas outside of New York City.
- **United Healthcare of New York, Inc. -** Revised COA to include the HARP line of business in their remaining approved Medicaid service areas outside of New York City.
- **Capital District Physician's Health Plan, Inc. -** Revised COA to include the HARP line of business in their approved Medicaid service areas.
- **Excellus Health Plan, Inc. -** Revised COA to include the HARP line of business in their approved Medicaid service areas.

B. Surveillance Activities

Surveillance activity completed during the 3rd Quarter FFY 2015-2016 (04/01/16 to 06/30/16) include the following:

- Three (3) Full Operational Surveys were completed during the 2nd Quarter FFY 2015-16. A Statement of Deficiency (SOD) was issued and a Plan of Correction (POC) was accepted.

  - MetroPlus Health Plan, Inc.
  - MetroPlus Health Plan, Inc. Special Needs Plan
  - AMERIGROUP New York, LLC
  - Yourcare

- Three (3) Targeted Operational Surveys were completed during the 3rd Quarter FFY 2015-16. An SOD was issued and a POC was accepted for two (2) Plans, and one (1) Plan was found in compliance:

  - VNS CHOICE
  - HealthNow New York Inc.

- Today's Options New York- (Found in compliance)

- Access and Availability Focus Surveys were completed on eighteen (18) Managed Care Plans during the 3rd Quarter FFY 2015-16. Letters of Concern were issued and a Corrective Action Plan was received for:

  - Affinity Health Plan, Inc.
  - Today's Option of New York, Inc.
  - MVP Health Plan, Inc.
  - Capital District Physicians' Health Plan, Inc.
  - Excellus Health Plan, Inc.
  - Independent Health Association, Inc.
  - Univera Community Health, Inc.
  - UnitedHealthcare of New York, Inc.
  - HealthFirst PHSP, Inc.
  - MetroPlus Health Plan, Inc.
  - HealthNow New York Inc.
  - MetroPlus Health Plan, Inc. Special Needs Plan
  - New York State Catholic Health Plan, Inc.
  - VNS CHOICE
  - Amida Care, Inc.
  - WellCare of New York, Inc.
  - AMERIGROUP New York, LLC
  - Health Insurance Plan of Greater New York

- The Primary Care Provider (PCP) Ratio Focus Survey was completed during the 3rd Quarter FFY 2015-16 with seventeen (17) Managed Care Plans receiving Letters of Concern and submitting Corrective Action Plans:

  - Affinity Health Plan, Inc.
  - Today's Option of New York, Inc.
  - MVP Health Plan, Inc.
  - Capital District Physicians' Health Plan, Inc.
  - Excellus Health Plan, Inc.
  - Independent Health Association, Inc.
  - Univera Community Health, Inc.
  - UnitedHealthcare of New York, Inc.
  - HealthFirst PHSP, Inc.
  - MetroPlus Health Plan, Inc.
  - HealthNow New York Inc.
  - MetroPlus Health Plan, Inc. Special Needs Plan
  - New York State Catholic Health Plan, Inc.

- Amida Care, Inc.
- WellCare of New York, Inc.
- AMERIGROUP New York, LLC
- Health Insurance Plan of Greater New York

V. Waiver Deliverables

A. Medicaid Eligibility Quality Control (MEQC) Reviews

Final reports have been submitted for all of the reviews except for the one involved in litigation. There are no changes from the last update.

- MEQC 2008 – Applications Forwarded to LDSS Offices by Enrollment Facilitators:
  No activities were conducted during the quarter. The review is involved in litigation.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Redeterminations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance:
  The final summary report was forwarded to the regional CMS office and CMS Central Office on July 1, 2015.

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability:
  The final summary report was forwarded to the regional CMS office on January 31, 2014 and CMS Central Office on December 3, 2014.

- MEQC 2011 – Review of Medicaid Self Employment Calculations:
  The final summary report was forwarded to the regional CMS office on June 28, 2013 and CMS Central Office on December 3, 2014.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications:
  The final summary report was forwarded to the regional CMS office on July 25, 2013 and CMS Central Office on December 3, 2014.

- MEQC 2013 – Review of Documentation Used to Assess Immigration Status and Coding:
  The final summary report was forwarded to the regional CMS office on August 1, 2014 and CMS Central Office on December 3, 2014.

B. Benefit Changes/Other Program Changes

Transition of Behavioral Health Services into Managed Care and Development of Health and Recovery Plans:

New York State is transitioning the full Medicaid behavioral health system to managed care. The goal is to create a fully integrated behavioral health (mental health and substance use disorder) and physical health service system that provides comprehensive, accessible, and recovery oriented services. There are three components of the transition: expansion of covered behavioral health services in Medicaid Managed Care, elimination of the exclusion for Supplemental Security Income (SSI), and implementation of Health and Recovery Plans (HARPs). HARPs are specialized plans that include staff with enhanced behavioral health expertise. For Medicaid Managed Care (MMC), all Medicaid-funded behavioral health services for adults, with the exception of services in Community Residences, will become part of the benefit package. Services in Community Residences and the integration of children's behavioral health services will move to Medicaid Managed Care at a later date.

As part of the transition, the New York State Department of Health (DOH) has begun phasing in enrollment of current MMC enrollees throughout New York State into HARPs beginning with adults 21 and over in New York City. This transition expanded to the rest of the state in July 2016. HARPs and HIV Special Needs Plans (HIV SNPs) now provide all covered services available through Medicaid Managed Care. All HARP enrollees are eligible for individualized care management. In addition, Behavioral Health Home and Community Based Services (BH HCBS) have been made available to eligible HARP and HIV SNP enrollees. These services are designed to provide enrollees with specialized supports to remain in the community and assist with rehabilitation and recovery.

Enrollees must undergo an assessment to determine BH HCBS eligibility as well as eligibility for specific BH HCBS. Effective January 2016 in NYC, BH HCBS were made available to eligible individuals. BH HCBS implementation will begin October 2016 for all regions outside of NYC. DOH, the New York State Office of Mental Health (OMH), and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) are continuing to meet biweekly with managed care plans and behavioral health providers to discuss stakeholder concerns and implementation challenges. The State plans to continue these meetings throughout the transition period and will be replicating these meetings outside of NYC to discuss issues specific to the Rest of State implementation. In addition, the State has contracted with the Managed Care Technical Assistance Center (MCTAC) to provide technical assistance to behavioral health providers in New York State, including technical assistance around billing managed care, contracting with managed care plans, and the new BH HCBS. The State has also provided education to Medicaid recipients throughout New York State about the changes to behavioral health that may affect them.

During the reporting period, the State has continued to provide ongoing technical assistance during the initial BH HCBS implementation period in NYC to Health Homes and Managed Care Organizations related to the completion of assessments and person-centered plans of care and delivery of the new BH HCBS. This technical assistance will be provided to Health Homes and

Managed Care Organizations in the rest of the state for the Rest of State BH HCBS implementation beginning in October 2016.

Transition of School-based Health Center Services from Medicaid Fee-for-Service:

The New York State Department of Health, School Based Health Center (SBHC) providers, managed care plans and other stakeholders continue to work together to ensure that children will continue to receive high quality services through SBCHs and access to improved care coordination during and after the transition of SBHC services to managed care. As a result of the 2016-2017 legislative budget process, the SBHC transition date has been extended to July 1, 2017. The reimbursement rate that the SBHCs currently receive in the Medicaid fee-for-service system will be maintained for at least two years after the transition to managed care. The additional year to transition will allow time for managed care plans and SBHC providers to complete contracting, provider credentialing and claims testing prior to the transition date.

C. Federally Qualified Health Services (FQHC) Lawsuit

No updates. Decision on wrap calculation is still pending.

D. Managed Long Term Care Program (MLTCP)

All MLTCP models provide a person-centered plan of care, integration of health care, environmental and social services, and a supportive transition from the previous, fragmented, FFS process to coordinated managed care.

1. Accomplishments

   During the period April 2016 through June 2016, there was no plan activity in terms of plan openings, closings, mergers, or service area expansions or withdrawals.

   New York's Enrollment Broker, NYMC, conducts the MLTC Post Enrollment Outreach Survey which contains questions specifically designed to measure the rate at which consumers are able to maintain their relationship with the services they were receiving prior to mandatory transition to MLTC. For the period April 2016 through June 2016, post enrollment surveys were completed for 25 enrollees. 68% of respondents indicated they continued to receive services from the same caregivers once they became members of an MLTCP. This represents a decrease in affirmative responses from 81% during Q2. Reasons for services not continuing included an agency closing, enrollees that no longer needed services, an agency that did not provide the services that were needed, and a consumer that chose to change agencies.

- **Enrollment:** Total enrollment in MLTC Partial Capitation Plans grew from 145,984 to 154,415 during the period April 2016 through June 2016. For that quarterly period, 12,760 individuals who were being transitioned into Managed Long Term Care from fee for service made an affirmative choice, bringing the 12-month total for affirmative choice to 52,473.

Plan specific enrollment on a monthly basis for the annual period of July 2015 through June 2016 is submitted as an attachment.

2. Significant Program Developments

   - During the period April 2016 through June 2016, one full operational MLTC partial cap plan audit was completed, resulting in the issuance of a SOD. A POC is currently pending. Two MLTC partial cap plan focused surveys and one Medicaid Advantage Plus (MAP) plan were also completed during this quarter, again each resulted in the issuance of an SOD. The resulting POC for each SOD is currently pending. Focused surveys of member services were completed on all partial capitation plans. SODs related to member services were not issued separately, but were incorporated into the SODs resulting from the operational or focused surveys.

   - During the period April 2016 through June 2016, ongoing refinement of the focused audit design and the comprehensive operational survey tool continued, as did survey staffing and training activities.

   - During the period April 2016 through June 2016, ongoing review of data to inform refinement of the 'secret shopper' process continued. Data from this process is incorporated into the survey process as part of the review of member services.

3. Issues and Problems

   - During the period April 2016 through June 2016, support to counties new to MLTC has not been needed. Effective October 1, 2015, the transition of the permanent nursing home population into MLTC was expanded to include voluntary option for residents who were permanently placed prior to effective date of the transition. In the past, district specific support has been offered and provided upon request, along with a number of training sessions and educational opportunities to reinforce basic protocols. Such support and training has not been requested during this quarter.

4. Summary of Self Directed Options

   - The transition of consumers receiving Consumer Directed Personal Assistance Service (CDPAS) was achieved during the October 2013 through September 2014 period. Self-direction is provided within the MLTCP as a consumer choice, and gives individuals and families greater control over services received. Plans continue to be required to contract with a minimum of two (2) Fiscal Intermediaries in each county. The requirement continues to be monitored on a quarterly basis, and all plans are meeting that requirement.

5. Required Quarterly Reporting

   - **Critical incidents:** The electronic reporting system has been implemented and will continue to be refined as needed. There were 192 critical incidents reported for the period

April 2016 through June 2016, representing an increase from 179 incidents reported during Q2.

- **Grievance and Appeals:** For the period April 2016 through June 2016, key areas of concern remain transportation and dissatisfaction with quality of home care.

Period: 4/01/16 - 6/30/16			
Number of Recipients: 162,888	**Grievances**	**Resolved**	**Percent Resolved**
# Same Day	5,981	5,981	100%
# Standard/Expedited	3,200	3,134	98%
Total for this period	9,181	9,115	99%

Appeals	**7/15-9/15**	**10/15-12/15**	**1/16-3/16**	**4/16-6/16**	**Average for Four Quarters**
Average Enrollment	140,873	146,196	154,436	162,888	151,099
Total Appeals	1,593	1,392	1,099	1,247	1,332
Appeals per 1,000	11	10	7	8	9
# Decided in favor of Enrollee	944	393	181	212	433
# Decided against Enrollee	875	637	513	700	682
# Not decided fully in favor of Enrollee	228	476	337	264	326
# Withdrawn by Enrollee	20	32	15	23	23
# Still pending	208	91	155	174	161
Average number of days from receipt to decision	13	13	12	11	12

Grievances and Appeals per 1,000 Enrollees
By Plan and Product Type
April 2016 – June 2016

Plan Name:	**Plan Type**	**Enrollment**	**Total Grievances**	**Grievances per 1,000**	**Total Appeals**	**Appeals per 1,000**
Partial Capitation Plans						
Aetna Better Health	Partial	3,688	85	23	22	6
AgeWell New York ,LLC	Partial	6,659	458	69	-	-
AlphaCare of New York Inc.	Partial	2,752	275	100	9	3
Amerigroup	Partial	3,290	69	21	-	-
ArchCare Community Life	Partial	2,080	238	114	8	4
CenterLight Healthcare Select	Partial	5,488	128	23	-	-
Centers Plan for Healthy Living	Partial	5,920	262	44	26	4
Elant Choice	Partial	862	5	6	-	-
ElderServe Health, Inc.	Partial	10,867	271	25	7	1
Elderwood	Partial	6	-	-	-	-
Extended	Partial	1,106	58	52	3	3
Fallon Health Weinberg	Partial	274	2	7	-	-

FIDELIS Care New York	Partial	13,686	456	33	5	-
GuildNet MLTCP	Partial	16,792	1,257	75	234	14
Hamaspik Choice	Partial	1,647	40	24	9	5
HomeFirst MLTC, a product of Elderplan	Partial	10,883	813	75	60	6
I Circle	Partial	1,220	18	15	1	1
Independence Care Systems	Partial	6,044	393	65	86	14
Integra MLTC	Partial	3,431	34	10	13	4
Kalos, dba First Choice Health	Partial	726	19	26	-	-
Metroplus	Partial	1,122	60	53	-	-
Montefiore Diamond Care	Partial	1,041	95	91	2	2
NSLIJ Health Plan	Partial	3,285	76	23	3	1
Prime Health Choice, LLC	Partial	172	6	35	-	-
Senior Health Partners	Partial	12,417	577	46	387	31
Senior Network Health	Partial	504	8	16	-	-
Senior Whole Health	Partial	4,949	186	38	13	3
United Healthcare Personal Assist	Partial	2,208	7	3	3	1
VillageCareMAX	Partial	6,071	1,315	217	12	2
VNA Homecare Options, LLC	Partial	2,130	63	30	-	-
VNSNY CHOICE MLTC	Partial	13,897	1,337	96	110	8
Wellcare	Partial	6,357	75	12	7	1
Total:		151,575	8,686	57	1,020	7
Medicaid Advantage Plus (MAP)						
Elderplan	MAP	1,029	111	108	11	11
Fidelis Medicaid Advantage Plus	MAP	134	2	15	-	-
GuildNet GNG	MAP	640	78	122	3	5
Healthfirst CompleteCare	MAP	3,760	15	4	187	50
HEALTHPLUS AMERIGROUP	MAP	3	-	-	-	-
Senior Whole Health	MAP	127	4	32	-	-
VNSNY CHOICE MLTC TOTAL	MAP	82	1	12	-	-
Total:		5,775	211	37	201	35
Program of All-inclusive Care for the Elderly (PACE)						
ArchCare Senior Life	PACE	500	45	90	-	-
Catholic Health LIFE	PACE	219	27	123	7	32
CenterLight Healthcare	PACE	3,209	73	23	10	3
Complete Senior Care	PACE	123	10	81	1	8
Eddy SeniorCare	PACE	181	27	149	-	-
ElderONE	PACE	670	53	79	4	6
Fallon Health Weinberg	PACE	35	15	429	-	-
Independent Living Services of CNY (PACE CNY)	PACE	488	23	47	4	8
Total Senior Care	PACE	113	11	98	-	-
Total:		5,538	284	51	26	5
Total for All Products:		162,888	9,181	56	1,247	8

Total Grievances reported increased from 7,300 in Q2 to 9,181 during the Q3 period of April 2016 through June 2016. The increase can largely be attributed to one plan's increase in enrollment, temporary discontinuation of a transportation provider, and temporary issues with the transportation provider's implementation of a new phone system. Those issues have been resolved, and the plan has already noticed a significant decrease in complaints.

Total number of appeals also increased from 1,096 during Q2 to 1,247 during the Q3 period of April 2016 through June 2016.

- **Fraud and Abuse:** For the period April 2016 through June 2016, there were 123 new potential cases of Fraud and Abuse detected, representing a decrease from Q2. Though still a significant increase over Q1, it is reasonable to believe that plans are now reporting more accurate data as a result of the Department's enhanced reviews that began in Q1 and that are designed to ensure that referrals to appropriate investigative agencies are being made by MLTC plans.

Fraud and Abuse Complaints	4/16-6/16
New potential cases of Fraud and Abuse detected during the reporting period	123
Open potential cases of Fraud and Abuse from previous quarter being investigated	38
Cases of Fraud and Abuse confirmed during the reporting period	20
Open potential cases of Fraud and Abuse remaining unconfirmed and still being investigated at the end of the reporting period.	60

- **Fair Hearings:**

Fair Hearing Decisions	4/16-6/16
In favor of Appellant	467
In favor of MLTC Plan	106
No Issue	9
Total	582

Fair Hearings: Days From Request To Decision	4/16–6/16
Less than 30 days	56
30 - 60 days	316

61 - 90 days	142
91 – 120 days	35
>120 days	33
Total Fair Hearing Decisions	**582**

- **Technical Assistance Center (TAC) Activity**

  - During the period from April 2016-June 2016, the Department continued to retrain staff on appropriate procedures for working with the new database. TAC staff also continued with the work-around that was put in place previously. The database was tested during the quarter, and full operation began in June 2016.

  - Third Quarter Highlights from MLTC-TAC:
    - The TAC unit continued to see an increase in billing issues and inquiries; however, a significant pattern has not yet emerged that would indicate one specific service being denied.
    - There was an uptick in enrollment applications not being processed timely, an area that was down in the previous quarter. This issue will be monitored to determine if the previous quarter was an anomaly.
    - The volume of complaints regarding non-ER transportation was low. It is anticipated that the volume of complaints may increase given the expansion into more rural counties.
    - Inquiries consist of MLTC-related questions on billing, eligibility or enrollment, for example, and questions that may not be MLTC related but require some investigation as to where the consumer should be directed for assistance. Inquiries increased 47% over last quarter.

    Complaint volume:
    - 370 substantiated complaints
    - 294 unsubstantiated complaints
    - 662 total complaints
    - 276 inquiries
    - 940 total call volume

    Complaint investigation activity:
    - Resulted in two (2) targeted corrective action plan
    - Issue: Enrollment-Assessment/Application-Not Timely
    - Impacted Regions: Albany and Kings counties

  - **Evaluations for enrollment:** The Conflict Free Evaluation and Enrollment Center (CFEEC) operations were fully implemented statewide by June 30, 2015. For the

period April 2016 through June 2016, 4,192 people were evaluated, deemed eligible and enrolled into plans.

- **Referrals and 30 day assessment:** For the period April 2016 through June 2016, total reported assessments conducted by the MLTC plans during the period were 10,394. The total number of assessments conducted this quarter has increased slightly, as has the percentage of assessments conducted within the 30-day time frame, which was at 86%. Due to the implementation of CFEEC on a statewide basis, data collection, evaluation, and reporting for this element continues to be monitored.

- **Referrals outside enrollment broker:** During the period April 2016 through June 2016, the number of people who were not referred by the enrollment broker and who contacted the plan directly was 14,263. This is an increase from 13,359 in Q2.

- **Rebalancing efforts:** Quarterly reporting of rebalancing efforts has been implemented, effective with the fourth quarter 2013 data submission. Previous data reported was based on a semi-annual data collection cycle.

Rebalancing Efforts	4/16-6/16
New Enrollees to the Plan from a nursing home transitioning to the community	508
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	1,867
Current plan Enrollees permanently placed in a nursing home	3,751
New Enrollees permanently placed in a nursing home who remain in a nursing home	2,113

Follow up with those plans that reported the largest increases during Q2 was completed. The number of current plan enrollees permanently placed in a nursing home was found to be 3,149, a slight decrease from the 3,432 that was originally reported. The Department has reiterated to plans that the data should reflect only those enrollees that have been permanently placed during the quarter. Quarterly report instructions are under revision to clarify and emphasize data reporting requirements.

VI. Evaluation of the Demonstration

The evaluation of the demonstration is being reviewed and revised as part of the 1115 Renewal process.

VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported 6,135 complaints/action appeals this quarter, an increase of 8.3% from the previous quarter. The most frequent category of complaint/appeal

was balance billing disputes, accounting for 20% of the total. There were 183 complaints/appeals reported by the HIV SNPs. The majority of these complaints (47) were in the category of Dissatisfaction with Provider Services (Non-Medical) or MCO Services. The Department directly received 330 Medicaid managed care complaints this quarter.

The top 5 most frequent categories of complaints were as follows:

20% Balance Billing
15% Advertising/ED/Outreach/Enrollment
14% Reimbursement/Billing Issues
11% Dental or Orthodontia
7% Dissatisfaction with Quality of Care

This quarter, Mainstream Medicaid Managed Care plans reported the following complaints and action appeals regarding long term services and supports. The Department did not identify any overall trends impacting enrollees' access to services:

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
AIDS Adult Day Health Care	0
Adult Day Care	0
Consumer Directed Personal Assistant	1
Home Health Care	5
Non-Permanent Residential Health Care Facility	2
Personal Care Services	8
Personal Emergency Response System	0
Private Duty Nursing	1
Total:	17

As SSI enrollees typically access long term services and supports, the Department monitors complaints and action appeals filed by this population with managed care plans. Of the 5,521 total reported complaints/action appeals, Mainstream Medicaid Managed Care plans reported 628 complaints and action appeals from their SSI enrollees. This compares to 736 SSI complaints/action appeals from last quarter. The top 5 categories of SSI complaints/action appeals reported were:

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Dental or Orthodontia	32%
Quality of Care	27%
Advertising/ED/Outreach/Enrollment	15%
Balance Billing	14%
All Other	11%

The total number of complaints/action appeals reported for SSI enrollees by category were:

Category	Number of Complaints/Action Appeals Reported For SSI Enrollees
Adult Day Care	0
Advertising/Education/Outreach/Enrollment	73
AIDS Adult Day Health Care	0
Appointment Availability - PCP	4
Appointment Availability - Specialist	2
Balance Billing	67
Communications/Physical Barrier	6
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	24
Dental or Orthodontia	155
Emergency Services	9
Eye Care	3
Family Planning	0
Home Health Care	2
Mental Health/Substance Abuse Services/ Treatment	28
Non-covered Services	19
Non-Permanent Resident Health Care Facility	1
Personal Care Services	5
Personal Emergency Response System	0
Pharmacy	26
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	44
Quality of Care	130
Recipient Restriction Program/Plan Initiated Disenrollment	0
Reimbursement/Billing Issues	30
Specialist or Hospital Services	5
Transportation	6
Waiting Time Too Long at Office	4
All Other Complaints	55
Total:	**698**

A. Medicaid Managed Care Advisory Review Panel (MMCARP) Meetings

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on June 23, 2016. The meeting included presentations provided by state staff and discussions of the following: an overview of the plan of correction (POC) process, including POC requirements, and a brief presentation on the network adequacy review process related to managed care plan service area expansions; updates on the status of the Managed Long Term Care (MLTC) and the Fully Integrated Duals Advantage (FIDA) programs, including Conflict Free Evaluation and Enrollment Center (CFEEC) activity, and an update on the State's efforts towards

operationalizing Community First Choice Option (CFCO); a discussion of current auto assignment statistics and state and local district outreach and other activities aimed at reducing auto assignment; and updates on the integration of mental health and substance use disorder services into the mainstream Medicaid managed care benefit package and the initiation of the Health and Recovery Plan (HARP) line of business in New York City, the status of the Rest of State (ROS) behavioral health transition scheduled for July 1, 2016, the status of the Children's Behavioral Health managed care timeline, and overviews of the role and implementation status of the Regional Planning Consortiums (RPCs) and the consumer forums for the ROS behavioral health transition. The next MMCARP meeting is scheduled for September 29, 2016.

B. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning Meetings were held on April 14, May 12, and June 9, 2016. The April meeting included the following: a brief overview of items included in the 2016-17 budget affecting Medicaid and managed care; an update on the status and timeline for Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC) capitation rates; an update on the Delivery System Reform Incentive Payment (DSRIP) program; updates on MLTC and Fully Integrated Duals Advantage (FIDA) program activities; a status update on the behavioral health managed care transition and Health and Recovery Plan (HARP) implementation, with a focus on New York City claims processing and the readiness review process for Rest of State behavioral health implementation, both mainstream and HARP; and an overview provided by staff from the Office for People with Developmental Disabilities of the FIDA-IDD implementation process. The May meeting agenda included: an overview of MMMC and MLTC finance and factors in rate development; an update on the Value Based Payment (VBP) roadmap, VBP Pilot programs, and the scheduled VBP boot camps; a presentation on using the DSRIP Performance Dashboard to assist in planning project roll-out; updates on MLTC and FIDA enrollment, activities of the Conflict-Free Evaluation and Enrollment Center (CFEEC), and the status of Community First Choice Option (CFCO); a presentation by the New York Association on Independent Living on Money Follows the Person and Independent Living Centers; and a discussion of the behavioral health transition and HARP implementation, including a Health Home update. Presentations, updates and discussions at the June meeting included: an overview of MMC and MLTC rate setting decisions; updates on FIDA, MLTC, CFCO and the workgroup activities related to the Nursing Home Transition and Diversion and Traumatic Brain Injury Waiver transition to managed care; an update on DSRIP status and related activities, including MCO dashboard access and the upcoming VBP boot camps; a presentation on the 2016-17 budget initiative to promote the use of and increase access to Long Acting Reversible Contraception (LARC); and an update on the Children's transition timeline and a discussion of claims testing for the July 1, 2016 ROS behavioral health and HARP transition. Managed Care Policy and Planning meetings during Federal Fiscal Year third quarter are scheduled for July 21, August 11, and September 8, 2016.

VIII. Quality Assurance/Monitoring

A. Quality Measurement in Medicaid Managed Care

Quality Assurance Reporting Requirements (QARR)
26 health plans submitted Quality Assurance Reporting Requirement (QARR) data on June 15, 2016. This includes data from all 14 Qualified Health Plans operating through the NY State of Health Marketplace. Data is being reviewed for completeness and accuracy, and final results will be published next quarter.

2015 Managed Long-Term Care Crude Percent Reports
In May, we released Crude Percent Reports for the July through December 2015 time period to the Managed Long-Term Care plans. These reports are plan-specific, reflective of each plan's July through December 2015 cohort of UAS-NY assessments, and utilize the latest, finalized patient assessment during this six-month time period.

The Crude Percent report provides a breakout by percentage (unless a metric is reported as an average) of each response level for most components of the Community Assessment, Functional Supplement, and Mental Health Supplement across two six-month time periods. Plans were also provided the percentages for the rest of the state with their plan excluded for comparison purposes. Plans were encouraged to review the reports, compare their results to previous data, and look at areas with changes from the previous reporting period to ensure data completeness.

2016 Managed Long-Term Care Consumer Guides
In June, the methodology and the measures to be used in the 2016 Managed Long-Term Care Regional Consumer Guides were distributed to the Managed Long-Term Care plans. The 2016 Ratings table will use the same main areas and measures (Preventive Care, Quality of Life, Stability or Improvement, and Satisfaction with Care) as in 2015.

The release of the Managed Long-Term Care Regional Consumer Guides is anticipated by the end of 2016. After release, the guides will be available on the Department's website (https://www.health.ny.gov/health_care/managed_care/mltc/) and will be included in member enrollment packets distributed by Maximus.

B. Quality Improvement

External Quality Review
The Island Peer Review Organization (IPRO) was awarded a 5 year contract in 2015 to continue to serve as New York State's External Quality Review Organization (EQRO). In that role, IPRO conducts Medicaid managed care external quality review activities on behalf of the state including: 1) Validation of performance improvement projects (PIPs);

2) Validation of performance measures; and 3) Review of MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement. In addition to these federally required activities, New York State DOH contracts with IPRO to conduct optional external review activities including: 1) Validating encounter and functional assessment data reported by the MCOs; 2) Administering or validating consumer satisfaction surveys; 3) Calculating performance measures in addition to those conducted by the MCO; 4) Conducting focused clinical studies; and 5) Implementation of PIPs required by the State in addition to those conducted by the MCO.

In this period, IPRO issued their final 2015 Provider Directory Survey reports to health plans. The first of two 2016 Provider Directory surveys was started and plan reports collected by IPRO for evaluation / citation determination. PCP Ratio Survey results were issued to health plans and IPRO coordinated collection of Corrective Action Plans.

They also began work on developing our new Provider Network Data Collection System (PNDS), complete with panel data reporting tool and data retrieval utilities. They established third party subcontracts to outsource necessary components of these projects. Meanwhile, they continued to oversee the ongoing collection of this data through the old system

IPRO initiated planning and survey development for an Encounter Data validation project which was subsequently postponed.

IPRO facilitated conference calls and meetings with MLTC plans to coordinate 2016 MLTC PIP activities and address issues encountered with reports or proposals. They reviewed interim reports for ongoing MLTC PIPs. For MMC PIPS, IPRO held ongoing conference calls and meetings with MMC plans throughout the quarter to discuss 2016 PIP related activities. Additional information on MMC PIPs can be found under the Performance Improvement Project description.

In this quarter IPRO worked on development and revision of 9 MLTC plan technical report drafts and 18 MMC plan PTRs.

They also developed the tool for the audit of the state's Uniform Assessment System (UAS), compiled contact lists, drafted letters, and received submission data for a sample of Traumatic Brain Injury (TBI) centers.

Work on a Prenatal Care quality improvement project was ongoing, with IPRO oversight of the Cohort identification, tool development, data collection, analysis, report generation, conference/webinar administration, and presentation of results. This time period saw completion of Cohort 1 from 2014, and development of a provider letters and a training for Cohort 2.

IPRO's oversight (external quality review) of performance measurement (QARR) included managing revision and changes in the Data Submission System for MMC, SNPs, and QHPs IPRO also assisted in development of a Care Management data collection system (CMART), and associated test files, facilitating planned onboarding of the system.

Performance Improvement Projects (PIPs)

For 2015-2016, the two-year common-themed PIP to address smoking cessation among Medicaid Managed Care (MMC) enrolled smokers is being implemented. Identification of MCO enrollees who are smokers is included as a major focus of the projects. Additionally, all plans are required to specifically improve access (and reduce barriers) to existing evidence based Medicaid benefits that reduce tobacco dependence and increase quit rates. A conference call with all of the Medicaid Managed Care plans, IPRO, and representatives from the NYSDOH Bureau of Tobacco Control and DPIPS, as well as the Office of Mental Health is planned for August 11, 2016. Three Medicaid Managed Care plans will present on their progress on the respective Smoking Cessation PIPs including: the project aim, performance indicators, interventions, preliminary data, barriers experienced, lessons learned, and next steps.

Breast Cancer Selective Contracting

Staff began work on the summer review of breast cancer surgical volume and will share results and provisional volume designations with facilities' SPARCS coordinators in summer 2016. It is anticipated that this process will make the breast cancer selective contracting process more efficient and reduce the number of appeals. Additionally, staff have begun an in-depth evaluation of the Breast Cancer Selective Contracting Policy and the impact of the policy on access to care, quality of care, and survival rates.

Patient Centered Medical Home (PCMH)

As of June 30, 2016, there were approximately 6,800 NCQA-recognized PCMH providers in New York State. Approximately 2,512 (37%) of these providers are recognized under the newest (2014) set of standards. We expect to see a continued increase in providers recognized under the 2014 standards because incentive amounts are structured to incentivize providers to achieve the highest standards (2014 level 2=$6PMPM and 2014 level 3=$8PMPM). Additionally, DSRIP requires participating providers to achieve 2014 level 3 PCMH recognition by March 31, 2018. Practices participating in the Adirondack Medical Home Demonstration have also committed to continue to maintain PCMH recognition under the 2014 standards as their 2011 recognitions expire. A recent analysis also showed that providers with higher Medicaid patient panels are more likely to have PCMH recognition in New York State compared to providers with lower Medicaid patient panels. This is most likely due to the incentive programs described.

The Adirondack Medical Home demonstration ('ADK'), a multi-payer medical home demonstration in the Adirondack region, has held monthly meetings for participating payers and will continue to do so through the end of 2016. There is a general commitment from payers and providers to continue the demonstration beyond its 12/31/2016 end date, however, discussions are ongoing. The governance committee is pursuing a new data warehouse vendor to evaluate the demonstration and conversations continue regarding the pay-for-performance component to the demonstration.

The September 2015 Statewide quarterly report was posted this quarter. All quarterly and annual reports on NYS PCMH and ADK program growth can be found on the MRT website, available here: http://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm.

In June 2016, a Medicaid Update article was released clarifying which patient populations are included in the PMPM incentive payments and which patient populations should not be included in the incentive: https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-06.htm#medhome.

IX. Transition Plan Updates

No updates for this quarter.

X. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

The budget neutrality quarterly report is not available, because NY is in the process of updating the specifications manual. There is an understanding with CMS that NY will work on updating the specifications manual before completing the quarterly reports; if not, the quarterly reports will be completed with inaccurate information.

B. Designated State Health Programs

No Updates for this quarter.

XI. Other

A. Transformed Medicaid Statistical Information Systems (T-MSIS)

New York has been working very closely with CMS as a front running state. New York is in Pre-Operational Readiness Testing (PORT) for T-MSIS Release 2.0. New York is submitting test files for all eight file types, reviewing results through the Operations Dashboard, entering issues/defects through JIRA and using HipChat for real-time communications with the T-MSIS support team.

B. Post-Award Forum- 1115 Waiver Public Comment Day (Downstate)

On May 4, 2016, DOH hosted a Public Comment Day in New York City which allowed for public comment on broad topics in the 1115 waiver, including DSRIP. A total of 39 speakers provided comment:

- 56% represented CBOs and included organized labor representatives. Concerns they expressed included: not receiving funding in a timely manner and that CBOs are being used as free consultants (they are not compensated for time and expertise)
- 11% represented PPSs as well as primary agencies. They expressed a need for capital to foster Primary Care, which is fundamental to the delivery of healthcare, as well as the need for a definition of Health Equity, Cultural Competency, and CBO diversity.
- A group of speakers raised concerns about water fluoridation. However, as the scope of the waiver does not cover this issue, NYS will seek to provide other avenues to address their concerns.

Specific issues discussed include the following:

- Workforce issues – training and retraining is not at the table; DSRIP information is being shared on a limited basis to downstream partners of the PPS
- Lack of data regarding people with disabilities; specific comments that healthcare should accommodate people with disabilities
- CBOs – Include CBOs to specifically address social determinates of health at a local level, such as to address racism, housing, and immigration. CBOs need resources for strategic planning; CBOs are not regularly included in PPS or Managed Care governance
- Need to align Medicaid, CHIP and Medicare
- Not enough time in DSRIP between DSRIP years 3-4 to make substantive corrections
- Address social determinants, gather housing data to track participants living with HIV
- Data is lost when blending services – cannot document where uninsured access care.

Several commenters provided written statements during and after the forum. These comments are archived in the following location:
http://www.health.ny.gov/health_care/medicaid/redesign/docs/1115_mwpcd_via%20email.pdf.

DOH will hold a second public forum in Albany on July 12, 2016. The events of the second forum, as well as NY's response the issues raised during both forums will be discussed in the Annual Report.

Attachments:

Attachment 1 - MLTC Partial Capitation Plans

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Upload to PMDA: August 30, 2016

Managed Long Term Care - Partial Capitation Plans

July 2015- June 2016

Plan Name	Jul-15 Enrollment	Aug-15 Enrollment	Sep-15 Enrollment	Oct-15 Enrollment	Nov-15 Enrollment	Dec-15 Enrollment	Jan-16 Enrollment	Feb-16 Enrollment	Mar-16 Enrollment	Apr-16 Enrollment	May-16 Enrollment	Jun-16 Enrollment
Aetna Better Health	3,147	3,154	3,210	3,258	3,303	3,363	3,447	3,530	3,583	3,629	3,688	3,746
AgeWell New York	4,814	4,931	5,124	5,274	5,471	5,666	5,895	6,125	6,334	6,502	6,674	6,800
AlphaCare	1,869	1,919	1,967	2,025	2,082	2,176	2,230	2,347	2,490	2,634	2,765	2,856
ArchCare Community Life	1,899	1,894	1,923	1,926	1,943	1,973	2,017	2,035	2,059	2,061	2,081	2,099
CCM Select	5,978	5,771	5,810	5,732	5,745	5,652	5,590	5,571	5,556	5,521	5,490	5,452
Centers Plan for Healthy Living	3,011	3,192	3,462	3,684	3,881	4,198	4,490	4,850	5,278	5,580	5,910	6,271
Elant	857	861	853	866	868	860	866	861	866	880	854	851
Elderplan	10,809	10,848	10,821	10,667	10,666	10,599	10,647	10,711	10,742	10,780	10,861	11,007
Elderserve	10,456	10,412	10,590	10,625	10,678	10,643	10,685	10,718	10,755	10,819	10,860	10,923
Elderwood	0	0	0	0	0	0	0	0	0	0	6	12
Extended MLTC	556	615	694	754	821	874	915	954	999	1,042	1,086	1,191
Fallon Health Weinberg (TAIP)	169	173	189	198	206	225	237	249	272	257	260	304
Fidelis Care at Home	9,490	9,626	10,048	10,134	10,747	11,243	11,735	12,067	12,661	13,178	13,707	14,173
Guildnet	14,064	14,102	14,271	14,402	14,557	14,781	16,643	16,708	16,737	16,804	16,823	16,749
Hamaspik Choice	969	1,042	1,131	1,202	1,275	1,339	1,398	1,492	1,539	1,599	1,641	1,700
HealthPlus- Amerigroup	2,589	2,563	2,589	2,602	2,669	2,790	2,901	2,971	3,053	3,179	3,281	3,409
HIP of Greater New York	1,279	1,263	1,293	1,288	1,303	1,311	36	11	3	0	0	0
iCircle Services	319	398	562	682	803	883	953	1,018	1,077	1,155	1,217	1,288
Independence Care Systems	5,377	5,356	5,473	5,503	5,647	5,729	5,788	5,840	5,925	5,986	6,042	6,104
Integra	2,440	2,458	2,556	2,660	2,769	2,950	2,886	3,093	3,199	3,289	3,408	3,596
Kalos Health- Erie Niagara	373	405	445	481	498	524	565	604	662	693	743	743
MetroPlus MLTC	883	874	876	897	923	939	978	1,004	1,027	1,062	1,106	1,199
Montefiore HMO	568	590	608	609	658	691	726	771	865	947	1,054	1,123
North Shore-LIJ Health Plan	2,048	2,113	2,254	2,351	2,479	2,585	2,735	2,848	2,965	3,139	3,271	3,445
Prime Health Choice	67	71	84	87	99	102	108	133	149	161	175	181
Senior Health Partners	13,808	13,583	13,758	11,855	12,761	12,759	12,645	12,538	12,463	12,408	12,390	12,452
Senior Network Health	481	483	494	499	490	493	488	495	507	506	503	504
Senior Whole Health	2,756	2,846	3,039	3,188	3,418	3,651	3,863	4,097	4,360	4,672	4,967	5,209
United Healthcare	1,324	1,336	1,394	1,437	1,524	1,633	1,735	1,879	2,014	2,113	2,206	2,306
Village Care	3,878	4,040	4,273	4,440	4,732	4,974	5,186	5,403	5,596	5,869	6,059	6,285
VNA HomeCare Options	713	800	952	1,060	1,212	1,410	1,577	1,693	1,841	1,985	2,112	2,294
VNS Choice	14,037	13,372	13,306	13,278	13,418	13,555	13,732	13,762	13,824	13,913	13,908	13,871
WellCare	7,137	7,207	7,231	7,226	7,201	7,134	7,115	6,837	6,583	6,423	6,376	6,272
TOTAL	**128,165**	**128,298**	**131,280**	**130,890**	**134,847**	**137,705**	**140,812**	**143,215**	**145,984**	**148,786**	**151,524**	**154,415**